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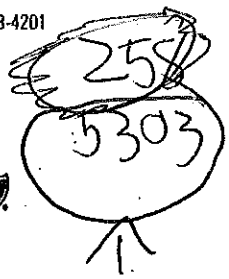

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March 4, 2010

Statement
Of
Anthem Blue Cross and Blue Shield
On
SB 258 An Act Concerning Appeals of Health Insurance Benefit Denials
And
HB 5303 An Act Requiring Reporting of Certain Health Insurance Claims Denial Data

Good afternoon Senator Crisco, Representative Fontana and members of the Insurance and Real Estate Committee, my name is Christine Cappiello and I am the Director of Government Relations for Anthem Blue Cross and Blue Shield in CT. I am here to testify against **SB 258 An Act Concerning Appeals of Health Insurance Benefit Denials and HB 5303 An Act Requiring Reporting of Certain Health Insurance Claims Denial Data.**

To begin, in regards to **SB 258,** we are unsure why this legislation is before you today. The utilization review statutes that were passed in 1997 and modified over the years have produced a process that allows for a fair and reasonable appeal process for the member, the treating provider and the insurer. This legislation upsets the delicate balance that over the years that this law has been in place.

Almost every section of this bill purports to take the current utilization process and turn it on its head and sets a standard where insurers would be left to approve and pay for any service that is requested because the administrative burden and inability to manage utilization will leave the carriers no other choice. One of the best examples of this is the proposed change to the definition of medical necessity to say the burden of proof to prove the service requested is not medically necessary. While on the face of it, this may seem like a consumer friendly notion, because of the short time frame that we have to make a decision on whether something is medically necessary we would rely on the requesting physician to provide the information to make the decision, but there is nothing to compel them to and we would left to approve a request because we could not meet the burden of proof standard for denying coverage. I have reached out to our Medical Directors to give some real life requests for coverage that, under this new burden of proof standard, we could be compelled to cover:

- Obesity surgery for people with body mass index under 25 (i.e. normal weight)
- Power wheelchair (usually around $10,000) for a person with a sprained ankle
- Coverage for a bicycle to travel to work
- Coverage for hot tubs
- 7 days inpatient stay requested so family could go camping
- Frequent requests for cosmetic procedures said to be medically necessary

Another great example of the unnecessary administrative burden that arises in this bill is the notion throughout the bill that we have to provide the provider or enrollee all the information, including what they have sent to us, that we used to make the decision. The real life implication of this concept is that we would be required by law to send back reams of medical records and doctors notes that were sent to us for a request for coverage. It doesn't seem to make any sense to have to mandate that in every case we send back to the provider the records they sent us to say nothing of the fact that we would be

required by law to send a provider confidential medical notes back to his/her patient, that the provider most likely does not want to share with them particularly in cases of mental health services.

We continue to ask ourselves, what is the goal of this legislation except to increase administrative costs and cause the insurer to contemplate even doing any utilization management at all, which is one of the fundamental reasons employers involve us in administering health benefits.

We want to leave the committee with this very important thought: The Legislature worked very hard to align the utilization process found in 38a-478n with federal Department of Labor regulations and have sensible criteria to govern the UR and appeal processes for Connecticut's citizens and this legislation will simply unravel that hard work and do nothing but add costs to the healthcare. We strongly urge the committee to reject **SB 258 An Act Concerning Appeals of Health Insurance Benefit Denials**

In regards to **HB 5303**, as the Committee is aware, we produce a substantial amount of information for the benefit of consumers in the Annual Managed Care Report Card. We are unsure of the value of this information to consumers and question whether this annual report contains too much information for consumers to digest. In addition, we ask that the Committee consider aligning this new information that we are being asked to report to be aligned with what we must report for the annual HEDIS survey so that the data is consistent.

Thank you for your attention to this matter and we welcome any questions you may have.